MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 26 TO FIND THE LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0685

WHO SHOULD COMPLETE THIS APPLICATION

Physicians and non-physician practitioners can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855I).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll/*.

Physicians and non-physician practitioners who are enrolled in the Medicare program, but have not submitted the CMS 855I since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855I) as an initial application when reporting a change for the first time.

All physicians, as well as all non-physician practitioners listed below, must complete this application to initiate the enrollment process:

Anesthesiology Assistant
Audiologist
Certified nurse midwife
Certified registered nurse anesthetist
Clinical nurse specialist
Clinical social worker
Mass immunization roster biller
Nurse practitioner
Occupational therapist in private practice
Physical therapist in private practice
Physician assistant
Psychologist, Clinical
Psychologist billing independently
Registered Dietitian or Nutrition Professional
Speech Language Pathologist

If your supplier type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete this application if you are an individual practitioner who plans to bill Medicare and you are:

- An individual practitioner who will provide services in a private setting.
- An individual practitioner who will provide services in a group setting. If you plan to render all of your services in a group setting, you will complete Sections 1-4 and skip to Sections 14 through 17 of this application.
- Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., you have added or changed a practice location).
- An individual who has formed a professional corporation, professional association, limited liability company, etc., of which you are the sole owner.

If you provide services in a group/organization setting, you will also need to complete a separate application, the CMS-855R, to reassign your benefits to each organization. If you terminate your association with an organization, use the CMS-855R to submit that change.

BILLING NUMBER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a Medicare healthcare supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at *https://NPPES.cms.gov*. For more information about NPI enumeration, visit *www.cms.gov/NationalProvIdentStand*.

The Medicare Identification Number, often referred to as a Provider Transaction Access Number (PTAN) or Medicare Legacy Number, is a generic term for any number other than the NPI that is used to identify a Medicare supplier.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

Type or print all information so that it is legible. Do not use pencil.

- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records.
- Send the completed application with original signatures and all required documentation to your designated fee-for-service contractor.

AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the correspondence address shown in Section 2 is the supplier's address.
- Enter your NPI in the applicable sections.
- Enter all applicable dates.
- Send the completed application with all supporting documentation to your designated fee-for-service contractor.

ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit *www.cms.gov/MedicareProviderSupEnroll*.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support and validate information reported on the application. You are responsible for providing this documentation in a timely manner.

Certain information you provide on this form is protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor (also referred to as a carrier or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to *www.cms.gov/MedicareProviderSupEnroll*.

SECTION 1: BASIC INFORMATION

A. Check one box and complete the required sections.

Since physician assistants do not complete Section 4, all physician assistants must furnish their Medicare Identification Number (if issued) and their NPI here:

Medicare Identification Number(s):_____ NPI:_____

If you are reassigning all of your Medicare benefits per section 4B1 of this application, furnish your Medicare Identification Number (if issued) and your individual (Type 1) NPI here:

Medicare Identification Number(s):_____ NPI:_____

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **enrolling with another fee-for-service contractor**	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **voluntarily terminating** your Medicare enrollment	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(if issued):* National Provider Identifier *(if issued):*	Sections **1A, 13** and **15** Physician Assistants must complete Sections **1A, 2F, 13** and **15** Employers terminating Physician Assistants must complete Sections **1A, 2G, 13** and **15**
☐ You are **changing** your Medicare information	Medicare Identification Number *(if issued):* NPI:	Go to Section **1B**
☐ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**

SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections.

	REQUIRED SECTIONS
☐ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13** and **15**
☐ Final Adverse Actions/Convictions	**1, 2A, 3, 13 and 15**
☐ Practice Location Information, Payment Address and Medical Record Storage Information	**1, 2A, 3, 4** (complete only those sections that are changing), **13** and **15**
☐ Individuals Having Managing Control	**1, 2A, 3, 6, 13,** and **15**
☐ Billing Agency Information	**1, 2A, 3, 8** (complete only those sections that are changing), **13** and **15**

SECTION 2: IDENTIFYING INFORMATION

A. Personal Information: Your name, date of birth, and social security number must coincide with the information on your social security record.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Other Name, First	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Type of Other Name

☐ Former or Maiden Name ☐ Professional Name ☐ Other *(Describe)*:_____

Date of Birth *(mm/dd/yyyy)*	State of Birth	Country of Birth

Gender ☐ Male ☐ Female	Social Security Number

Medical or other Professional School *(Training Institution, if non-MD)*	Year of Graduation *(yyyy)*	DEA Number *(if applicable)*

License Information

☐ License Not Applicable

License Number	State Where Issued

Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Certification Information

☐ Certification Not Applicable

Certification Number	State Where Issued

Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

New Patient Status Information

Do you accept new Medicare patients? ☐ Yes ☐ No

B. Correspondence Address

Provide contact information for the person shown in Section 2A above. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*

Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

C. Resident/Fellow Status

1. Are you currently in an approved training program as:
   a. A resident? ☐ YES ☐ NO
   b. In a fellowship program? ☐ YES ☐ NO

   • If NO, skip to Section 2D.
   • If YES to either of the above questions, provide the name and address of the facility where you are a resident or fellow on the following lines:

   _____

   _____

   _____

2. Are the services that you render at the facility shown in Section 2C1 part of your requirements for graduation from a formal residency or fellowship program? ☐ YES ☐ NO

   Date of Completion:_____. If your completion date is prior to the beginning date for your practice in Section 4, skip to Section 2D.

3. Do you also render services at other facilities or practice locations? IF YES, you must report these practice locations in Section 4. ☐ YES ☐ NO

4. Are the services that you render in any of the practice locations you will be reporting in Section 4 part of your requirements for graduation from a residency or fellowship program? ☐ YES ☐ NO

IF YES, has the teaching hospital reported in Section 2C1 above agreed to incur all or substantially all of the costs of training in the non-hospital facility. ☐ YES ☐ NO

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

D. 1. Physician Specialty

Designate your primary specialty and all secondary specialty(s) below using:
P=Primary S=Secondary

You may select only one primary specialty. You may select multiple secondary specialties. A physician must meet all Federal and State requirements for the type of specialty(s) checked.

- ☐ Addiction medicine
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac surgery
- ☐ Cardiovascular disease (Cardiology)
- ☐ Chiropractic
- ☐ Colorectal surgery (Proctology)
- ☐ Critical care (Intensivists)
- ☐ Dermatology
- ☐ Diagnostic radiology
- ☐ Emergency medicine
- ☐ Endocrinology
- ☐ Family practice
- ☐ Gastroenterology
- ☐ General practice
- ☐ General surgery
- ☐ Geriatric medicine
- ☐ Gynecological oncology
- ☐ Hand surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hospice
- ☐ Infectious disease
- ☐ Internal medicine
- ☐ Interventional Pain Management
- ☐ Interventional radiology
- ☐ Maxillofacial surgery
- ☐ Medical oncology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Oral surgery (Dentist only)
- ☐ Orthopedic surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Palliative Care
- ☐ Pathology
- ☐ Pediatric medicine
- ☐ Peripheral vascular disease
- ☐ Physical medicine and rehabilitation
- ☐ Plastic and reconstructive surgery
- ☐ Podiatry
- ☐ Preventive medicine
- ☐ Psychiatry
- ☐ Psychiatry (geriatric)
- ☐ Pulmonary disease
- ☐ Radiation oncology
- ☐ Rheumatology
- ☐ Sports Medicine
- ☐ Surgical oncology
- ☐ Thoracic surgery
- ☐ Urology
- ☐ Vascular surgery
- ☐ Undefined physician type

(Specify):_____

D. 2. Non–Physician Specialty

If you are a non-physician practitioner, check the appropriate box to indicate your specialty.

All non-physician practitioners must meet specific licensing, educational, and work experience requirements. If you need information concerning the specific requirements for your specialty, contact the Medicare fee-for-service contractor.

Check only one of the following: If you want to enroll as more than one non-physician specialty type, you must submit a separate CMS-855I application for each.

- ☐ Anesthesiology assistant
- ☐ Audiologist
- ☐ Certified nurse midwife
- ☐ Certified registered nurse anesthetist
- ☐ Clinical nurse specialist
- ☐ Clinical social worker
- ☐ Mass immunization roster biller
- ☐ Nurse practitioner
- ☐ Occupational therapist in private practice
- ☐ Physical therapist in private practice
- ☐ Physician assistant
- ☐ Psychologist, clinical
- ☐ Psychologist billing independently
- ☐ Registered dietitian or nutrition professional
- ☐ Speech Language Pathologist
- ☐ Undefined non-physician practitioner type *(Specify)*:

_____

_____

_____

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

E. Physician Assistants: Establishing Employment Arrangement(s)

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	EMPLOYER'S NPI	EMPLOYER'S EIN

F. Physician Assistants: Terminating Employment Arrangement(s)

Complete this section if you are a physician assistant discontinuing your employment with a practice.

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	EMPLOYER'S NPI	EMPLOYER'S EIN

G. Employer Terminating Employment Arrangement with One or More Physician Assistants

This section should be used by an individual who has incorporated or is a sole proprietor, and who is discontinuing their employment arrangement with a physician assistant.

PHYSICIANS ASSISTANT'S NAME	EFFECTIVE DATE OF DEPARTURE	PHYSICIANS ASSISTANT'S MEDICARE IDENTIFICATION NUMBER A (IF ISSUED)	PHYSICIANS ASSISTANT'S NPI

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

H. Clinical Psychologists

Do you hold a doctoral degree in psychology? ☐ YES ☐ NO

If YES, furnish the field of your psychology degree_____

Attach a copy of the degree with this application.

I. Psychologists Billing Independently

1. Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ☐ YES ☐ NO
2. Do you treat your own patients? ☐ YES ☐ NO
3. Do you have the right to bill directly, and to collect and retain the fee for your services? ☐ YES ☐ NO
4. Is this private practice located in an institution? ☐ YES ☐ NO

   If YES to question 4 above, please answer questions "a" and "b" below.

   a) If your private practice is located in an institution, is your office confined to a separately identified part of the facility that is used solely as your office and cannot be construed as extending throughout the entire institution? ☐ YES ☐ NO

   b) If your private practice is located in an institution, are your services also rendered to patients from outside the institution or facility where your office is located? ☐ YES ☐ NO

J. Physical Therapists/Occupational Therapists in Private Practice (PT/OT)

The following questions only apply to your individual practice. They do not apply if you are reassigning all of your benefits to a group/organization.

1. Are all of your PT/OT services only rendered in the patients' homes? ☐ YES ☐ NO
2. Do you maintain private office space? ☐ YES ☐ NO
3. Do you own, lease, or rent your private office space? ☐ YES ☐ NO
4. Is this private office space used exclusively for your private practice? ☐ YES ☐ NO
5. Do you provide PT/OT services outside of your office and/or patients' homes? ☐ YES ☐ NO

If you respond YES to any of the questions 2–5 above, attach a copy of the lease agreement that gives you exclusive use of the facility for PT/OT services.

K. Nurse Practitioners and Certified Clinical Nurse Specialists

Are you an employee of a Medicare skilled nursing facility (SNF) or of another entity that has an agreement to provide nursing services to a SNF? ☐ YES ☐ NO

If yes, include the SNF's name and address.

Name		
Street Address		
City	State	Zip

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

L. Advanced Diagnostic Imaging (ADI) Suppliers Only

This section must be completed by all individual practitioners that also furnish and will bill Medicare for ADI services. All individual practitioners furnishing ADI services MUST be accredited in each ADI Modality checked below to qualify to bill Medicare for those services.

Check each ADI Modality that you will furnish and the name of the Accrediting Organization that accredited you for that ADI Modality.

☐ **Magnetic Resonance Imaging (MRI)**

Name of Accrediting Organization for MRI	
Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Computed Tomography (CT)**

Name of Accrediting Organization for CT	
Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Nuclear Medicine (NM)**

Name of Accrediting Organization for NM	
Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Positron Emission Tomography (PET)**

Name of Accrediting Organization for PET	
Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against you?

☐ YES–Continue Below	☐ NO–Skip to Section 4

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 4: PRACTICE LOCATION INFORMATION

A. Establishing a Professional Corporation, Professional Association, Limited Liability Company, etc.

If you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, complete this section 4A, skip to Section 4C, and complete the remainder of the application with information about your business entity.

Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number
Medicare Identification Number *(if issued)*	NPI
Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Services (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☐ No

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership ☐ Sole Proprietor ☐ Other *(Specify)*: _____

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.)

☐ Proprietary ☐ Non-Profit

NOTE: If a checkbox indicating Proprietaryship or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

FINAL ADVERSE LEGAL ACTION HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse legal actions listed on page 12 of this application imposed against it?

   ☐ YES–Continue Below ☐ NO–Skip to Section 4B

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

If you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, you do not need to complete a CMS-855R that reassigns your benefits to the business entity.

B. Individual Affiliations

Complete this section with information about your private practice and group affiliations.

Furnish the requested information about each group/organization to which you will reassign your benefits. In addition, either you or each group/organization reported in this section must complete and submit a CMS 855R(s) (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill and receive payment from Medicare for the services you have rendered at the group/organization's practice location.

If you are an individual who is reassigning all of your benefits to a group, neither you nor the group needs to submit a CMS-588 (Electronic Funds Transfer Authorization Agreement) to facilitate that reassignment.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

1. If you are reassigning all of your payments to another group or organization furnish the name, Medicare identification number(s) and NPI of each group or organization below and proceed to Section 13.
2. If any of your payments are part of your private practice and a group or organization furnish the name and Medicare identification number(s) and NPI of each group or organization below and continue to Section 4C (where you will enter your private practice information).
3. If you are not reassigning all or any of your payments to another group or organization, skip to Section 4C with information about your private practice.

a) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
b) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
c) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
d) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
e) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier

C. Practice Location Information

- If you completed Section 4A, complete Section 4C through Section 17 for your business.
- All locations disclosed on claims forms should be identified in this section as practice locations.
- Complete this section for each of your practice locations where you render services to Medicare beneficiaries.

  However, you should only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you render services in a hospital and/or other health care facility, furnish the name and address of that hospital or facility.
- Each practice location must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box.
- If you only render services in patients' homes (house calls), you may supply your home address in this section if you do not have an office. In Section 4H, explain that this address is for administrative purposes only and that all services are rendered in patients' homes.
- If you render services in a retirement or assisted living community, complete this section with the names, telephone numbers and addresses of those communities.

If you have a CLIA number and/or FDA/Radiology Certification Number for this practice location, provide that information and submit a copy of the most current CLIA and FDA certification for each practice location reported.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

If you or your organization sees patients in more than one practice location, copy and complete this Section 4C for each location.

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE *(mm/dd/yyyy)*			

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number *(if issued)*	NPI

Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*

Is this practice location a:

☐ Group practice office/clinic
☐ Hospital
☐ Retirement/assisted living community
☐ Skilled Nursing Facility and/or Nursing Facility
☐ Other health care facility
*(Specify):*_____

CLIA Number for this location *(if applicable)*	FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

D. Rendering Services in Patients' Homes

List the city/town, State, and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855I) for each Medicare fee-for-service contractor's jurisdiction.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

E. Where Do You Want Remittance Notices or Special Payments Sent?

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Medicare will issue payments via electronic funds transfer (EFT). Since payment will be made by EFT, the "Special Payments" address will indicate where all other payment information (e.g., remittance notices, special payments) are sent.

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4C). Skip to Section 4F.

☐ "Special Payments" address is different than that listed in Section 4C, or multiple locations are listed. Provide address below.

Furnish the address where remittance notices and special payments should be sent for services rendered at the practice location(s) in Section 4C. Note that payments will be made in your name; if an entity is listed in Section 4A of this application, payments will be made in the organization's name.

"Special Payment" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payment" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

F. Employer ID Number Information

NOTE: If you are a sole proprietor and you want Medicare payments to be reported under your EIN, list it below. Unless indicated in this section, payments will be made to your SSN. You cannot use both an SSN and EIN. You can only use one EIN to bill Medicare.

To qualify for this payment arrangement, you:

- Must be a sole proprietor,
- Cannot reassign all of your Medicare payments, and,
- Want your payments to be made to your EIN. Furnish IRS documentation showing your EIN.

Employer Identification Number (EIN)

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

G. Where Do You Keep Patients' Medical Records?

If the patients' medical records are stored at a location other than the location shown in Section 4C, complete this section with the name and address of the storage location. This includes both current and former patients' records.

Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. The records must be your records, not those of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4C.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Second Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

H. Unique Circumstances

Explain any unique circumstances concerning your practice locations or the method by which you render health care services (e.g., you only render services in patients' homes [house calls only]).

SECTION 5: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 6: INDIVIDUALS HAVING MANAGING CONTROL

This section captures information about all managing employees. A managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

All managing employees at any of your practice locations shown in Section 4 must be reported in this section. If there is more than one managing employee, copy and complete this section as needed.

A. Managing Employee Identifying Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

First Name	Middle Initial	Last Name	Jr., Sr., etc.	Title

Medicare Identification Number *(if issued)*	NPI *(if issued)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth

What is the effective date this individual acquired managing control of the provider identified in Section 2A of this application? *(mm/dd/yyyy)*

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If you are changing or adding information, check the "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change

Effective Date:_____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 8

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 7: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

CHECK HERE ☐ If this section does not apply and skip to Section 13.

If you are changing, adding, or deleting information, check the applicable box and furnish the effective date.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Billing Agency Name and Address

Complete the appropriate fields in this section.

Legal Business Name *(as Reported to the Internal Revenue Service)*	If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*
"Doing Business As" Name *(if applicable)*	Tax ID Number or Social Security Number *(required)*
Billing Agency Address Line 1 *(Street Name and Number)*	
Billing Agency Address Line 2 *(Suite, Room, etc.)*	

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 12: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 13: CONTACT PERSON

This section captures information regarding the person you would like for us to contact regarding this application. If no one is listed below, we will contact you directly.

First Name	Middle Initial	Last Name	Jr., Sr., etc.

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 1.18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

   The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…a claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.

6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met.

Certification Statement

You MUST sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.
2. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of a change in ownership, practice location and/or Final Adverse Action within 30 days of the reportable event. In addition, I agree to notify the Medicare contractor of any other changes to the information to this form within 90 days of the effective date of change. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in business structure of this supplier may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 4A of this application. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
5. Neither I, nor any managing employee listed on this application, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
6. I agree that any existing or future overpayment made to me (or to the organization listed in Section 4A of this application) by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
NOTE: If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)

☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.

☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)

☐ Copy of current CLIA and FDA certification for each practice location reported.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider Enumeration System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

The supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.